BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

1981 ANNUAL REPORT

CONTENTS

IN MEMORIAM

Members of the Board of Directors, the Active Members, and employees of the Florida Plan have all been deeply saddened by the sudden death of G. Emerson Tully, Chairman of the Board of Directors of Blue Cross and Blue Shield of Florida, Inc. Mr. Tully died in Tallahassee on April 23, 1982.

Mr. Tully began his service with the Florida Plan in 1966, when he was first elected to the Board of Directors of Blue Cross of Florida. He later became Chairman of the Blue Cross Board and was instrumental in the consolidation of Blue Cross and Blue Shield into one corporation under a single Board in 1980. Upon consolidation, Mr. Tully was elected Chairman of the Blue Cross and Blue Shield Board, a post he held until his death.

A tireless worker and supporter of the Florida Plan, Mr. Tully was, at the time of his death, a professional associate for the American College Testing Program in the Tallahassee Regional Office. He also served as a former member and past president of the Board of Trustees of Tallahassee Memorial Hospital.

Until the next annual election of Board officers, Dr. Joseph G. Matthews, Board Vice Chairman, will preside over meetings of the Board. Dr. Matthews joined the Board of Florida Blue Shield in 1971, and was its chairman from 1974 to 1980. He has served as Vice Chairman of the Florida Plan since the two companies consolidated in July 1980.

VICE CHAIRMAN'S MESSAGE

Dear Fellow Floridians:

During 1981, Blue Cross and Blue Shield of Florida continued to address the major concern of everyone who provides or receives health care services: the cost of these services.

Some recent figures on the cost of health care make it clear just how serious this problem has become. During the past decade, health care costs have increased from $27 billion in 1971 to $275 billion in 1981.

Nationwide, the increase in the cost of health care has far outstripped inflation in the economy in general. In 1955, health care expenditures equalled only 4.4 percent of the Gross National Product, while in 1981, they rose to 9.4 percent of the GNP. Personal health care costs increased by an average of over 13 percent per capita each year of the last decade. No other component of the Consumer Price Index exceeded medicine's 12.5 percent increase in 1981.

In Florida, the problem of rising health care costs is particularly acute. Florida hospital charges are increasing at just over 14 percent per year. Hospital revenue is increasing at a rate greater than 20 percent because of inflation and increased utilization due largely to advances in technology and changes in population.

No single group can solve the cost problem that plagues America's health care system. But it is the duty of every health insurer, physician, health care administrator, and private citizen to take a closer look at the problem. And at Blue Cross and Blue Shield of Florida, we think we're addressing the problems and developing solutions to rising health care costs more effectively than any other insurance company in the state. Our approaches are outlined in this report.

Joseph G. Matthews, M.D.
Vice Chairman of the Board

PRESIDENT'S MESSAGE

Dear Fellow Floridians:

In many ways, Blue Cross and Blue Shield of Florida is uniquely equipped to address problems of health care financing. We were the original health service plan in the state, and our origins have given us a unique position among members of the health care community. When our antecedent companies were founded in the mid-1940s, they formed an alliance between physicians and hospitals and the communities they serve. More than any other insurer, Blue Cross and Blue Shield of Florida has traditionally been a mediator, bringing together groups within the health care community.

This unique position has enabled the Plan to orchestrate solutions that extend beyond the interests of any one group—solutions that can work.

We can slow the rise in health care costs if joint action is taken. At Blue Cross and Blue Shield of Florida, we're doing our part. Far more than any other Florida insurer, we have committed resources to developing and implementing programs that can help restrain costs under the present system; and we are also venturing into new, cost-effective ways of providing or administering health care services. In doing so, the Plan's primary goal has been to find lower-cost alternatives to our present health care delivery system without sacrificing the quality and accessibility of health care services for our subscribers.

For the past several years, Blue Cross and Blue Shield of Florida has been putting in place a wide range of programs that should go far in demonstrating the effectiveness of private initiatives in health care administration. We are addressing these concerns on three levels:

1) Internally, through increased administrative efficiency.
2) Jointly, through cooperative programs with health care providers and consumers.
3) Through innovation, by developing alternatives to traditional health care delivery systems and new ways of financing and administering the business.

It is not an easy task, but we are beginning to achieve results. That is why this year's Annual Report asks you to take a closer look—at the health care system, at our company, and at our initiatives to save health care dollars.

William E. Flaherty

William E. Flaherty
President

INCREASING OUR EFFICIENCY

In order to provide better value for customers' premium dollars, Blue Cross and Blue Shield of Florida has been finding ways to increase its own efficiency and trim its expenses. During 1981, revenues generally lagged behind rising claims costs, in part due to regulatory delays in rate approvals for some lines of business, and in part due to competitive pressure and marketplace shifts. As a result, the Plan intensified its efforts to promote administrative efficiencies—changes that may ultimately help to hold down its operating costs for consumers.

SUPERIOR SERVICE AT LOWER COSTS

Better, quicker, and less costly customer services were achieved through a combination of systems improvements and more efficient staff management in Private Business Claims and Customer Relations areas.

For example, Florida Blue Cross and Blue Shield has designed an easily understandable Explanation of Benefits (EOB) form. The new form uses layman's language to make it easier for subscribers to understand their claims payments. Some 40 percent smaller than the previous form, the new EOB combines all claims information in a single page, and includes, where necessary, a new "patient responsibility" column that spells out the subscriber's own financial responsibility after the claim is processed. Due mainly to lower postage costs with the smaller form, some $600,000 in savings

should accrue to the company annually as a result of this program. We also expect to receive fewer inquiries due to more complete customer understanding of the new EOB form.

The Plan also instituted a new Medical Policy Task Force in 1981. This Task Force reviews current policy in light of the concerns raised by subscribers about the grounds on which claims are paid or denied, and the efficient delivery of needed medical care. Once the review is complete, the Task Force implements corrective actions that ensure consistent, fair treatment for all subscribers.

A program designed to provide superior customer service was launched in October 1981. It is designed to improve the quality and timeliness of services delivered to subscribers and to providers of care. Current activities include improving the level of service at Plan offices statewide, closely monitoring the type and quality of service delivered, and enhancing communications with Plan subscribers.

Since December 1981, the Plan has also conducted a monthly analysis of the causes for inquiries and adjustments to claims. Each month, specific lines of business are examined, and programs for corrective action are implemented.

In support of the corporate goal of superior customer service, a regular consumer research survey was created to solicit opinions about the company's service from subscribers, physicians, hospitals, and group decisionmakers. Also beginning in 1981, subscribers were interviewed by telephone on a quarterly basis to measure their level of satisfaction with Blue Cross and Blue Shield. This data will be utilized as we continue to make improvements in our subscriber services.

The Provider and Professional Relations division also initiated new efficiencies during 1981. Plan/provider contacts were transformed from a previous one-on-one orientation to a seminar-and-workshop format in which more people could be reached at lower cost. During the year, 462 such workshops were held statewide, reaching over 23,000 health care professionals and providers.

Ultimately, the most critical factor in achieving organizational effectiveness and financial control is better organizational and personal performance levels from all of our employees. With this in mind, the Plan's Human Resources area in 1981 initiated a five-year Management Development Program in conjunction with the University of Chicago. The program offers a series of intensive management development seminars and work experiences from senior to supervisory levels, using a "top-down" approach.

BETTER SYSTEMS AND BETTER DATA

In addition to organizational changes aimed at improving customer service and the quality of management, Blue Cross and Blue Shield of Florida also implemented electronic data systems

changes that improved customer service and lowered costs.

One example is the Claims Realignment Project, which combines a data-entry system for all private-sector lines of business. This has provided greater commonality for all private claims processing, and therefore, has cut paperwork, training costs, and increased productivity. The result is a lower unit-cost per claim processed, with an expected savings in excess of $500,000 annually.

The company also began development of a new actuarial system in 1981. To be fully implemented in 1983, this computer system will enhance the company's ability to analyze and forecast trends based upon actuarial data and to more accurately price various product offerings.

Blue Cross and Blue Shield of Florida also implemented an improved accounting system for group subscribers, designed to strengthen financial controls and streamline administrative procedures.

Realizing a need for better information on which to base business decisions, the company strengthened its research and analysis capabilities. A new department, Corporate Research, was added to monitor industry trends, conduct special studies for long-range planning, and serve as a clearinghouse for information company-wide. Staffing for the Marketing Research and Corporate Planning areas was strengthened. In addition, "user-friendly" computer systems were installed in 1982, making it possible for areas within the company, such as Actuarial and Marketing Research, to have direct access to computers enabling them to develop and analyze information to suit their needs.

IMPROVEMENTS IN MEDICARE

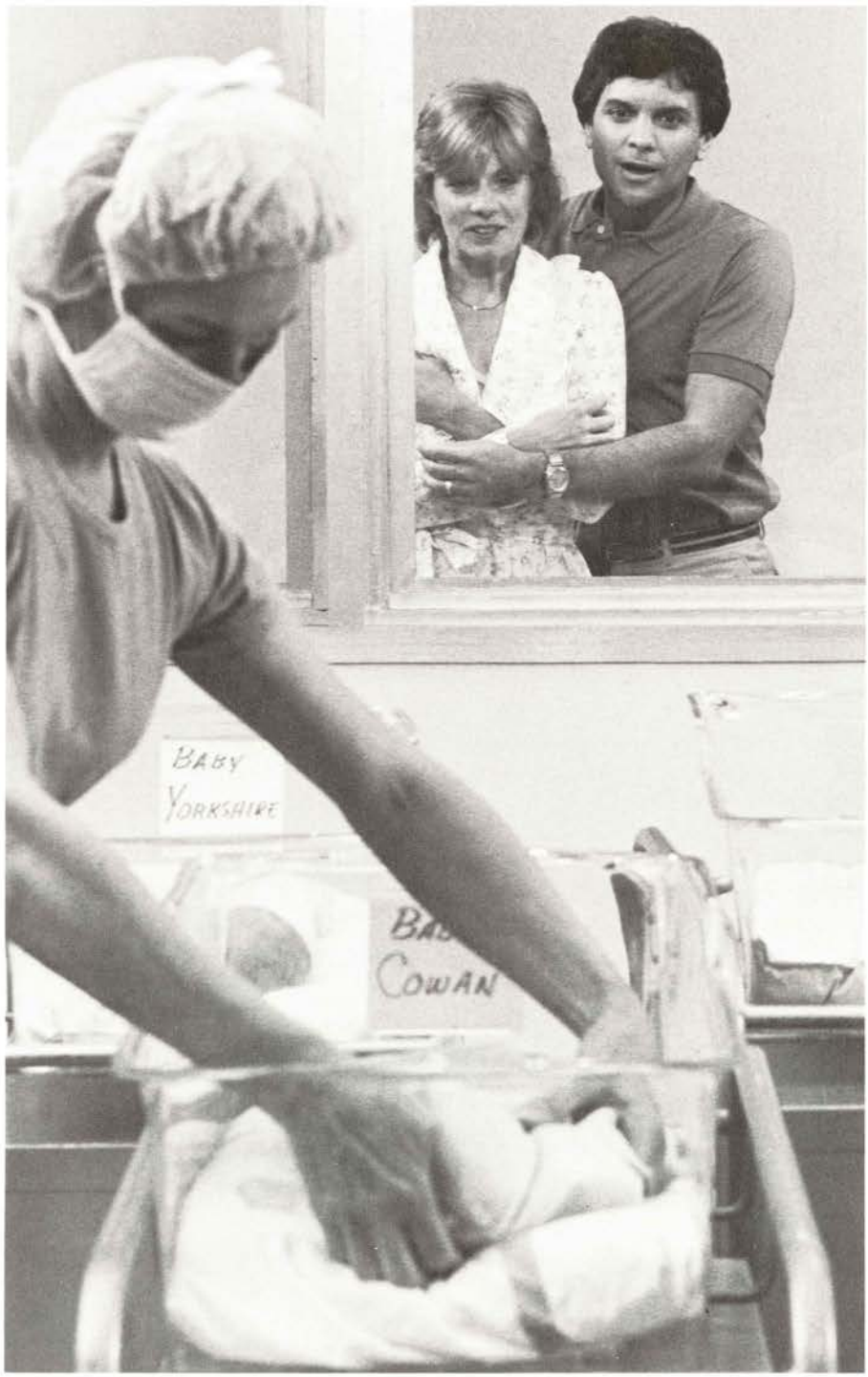
During 1981, the Medicare side of the business continued its high performance, despite cuts in government funding for the program. Medicare A—which handles hospital services—had a slight increase in administrative costs per claim during the year, to $4.98 from $4.94 in 1980. However, this increase was more than offset by a continuing decrease in the Medicare B (doctors' services) cost per claim, down to $2.20 in 1981, from $2.23 the previous year.

Of the nine largest Medicare B carriers in the nation, the Florida Plan in fiscal year 1981 had the lowest average cost per claim. Blue Cross and Blue Shield processed nearly 10 million claims during this period at a cost per claim of $2.20 compared to a national average of $2.68. The Florida Plan also ranked among the top Medicare administrators in the nation in terms of productivity measurements, which gauge the efficiency with which claims are processed. In fiscal year 1981, Blue Cross and Blue Shield's Medicare area processed 914 claims per 100 corporate manhours, compared to the national average of 626 claims per 100 manhours, making it one of the most efficient Medicare processors in the U.S.

In fact, cost and productivity results were so favorable that on July 1, 1982, the Health Care Financing Administration announced that, effective Oct. 1, it was awarding the Florida Plan a contract to administer Medicare B claims processing in Dade and Monroe counties. With the award of the new contract, the Florida Plan will become the largest Medicare B administrator in the nation.

The year 1981 saw a variety of new programs aimed at improving service, lowering costs, and developing better controls and data. Some of these administrative improvements can be directly perceived by the beneficiaries we serve. Others—such as improved computer systems and better recordkeeping— are not as visible. However, they are a significant part of the corporate effort to hold back the rising costs of financing health care. More efficient administration of our business can't hold back health care costs alone, but it is one important factor that increasingly will benefit the company and the public in the years to come.

MARKETING IN THE EIGHTIES



Although the marketing environment has become increasingly competitive, nearly every one of the Florida Plan's lines of business made moderate-to-significant gains in 1981. Only the local-group segment had a loss of enrollment. This was attributed primarily to the very large size of the rate increases required of almost all of these groups in 1981.

The company did bid successfully on two major accounts in the first quarter of 1982. It was awarded a contract with the Hospital Corporation of America, expected to add 11,000 new Major Medical contracts in 1982. It also bid successfully to continue to administer the Florida State Employees' account through mid-year 1986, averaging 80,000 contracts a year. Also in 1981, the Florida Plan's Federal Employees Program led all other Plans nationwide in enrollment gains for the third consecutive year, picking up 1,291 new contracts.

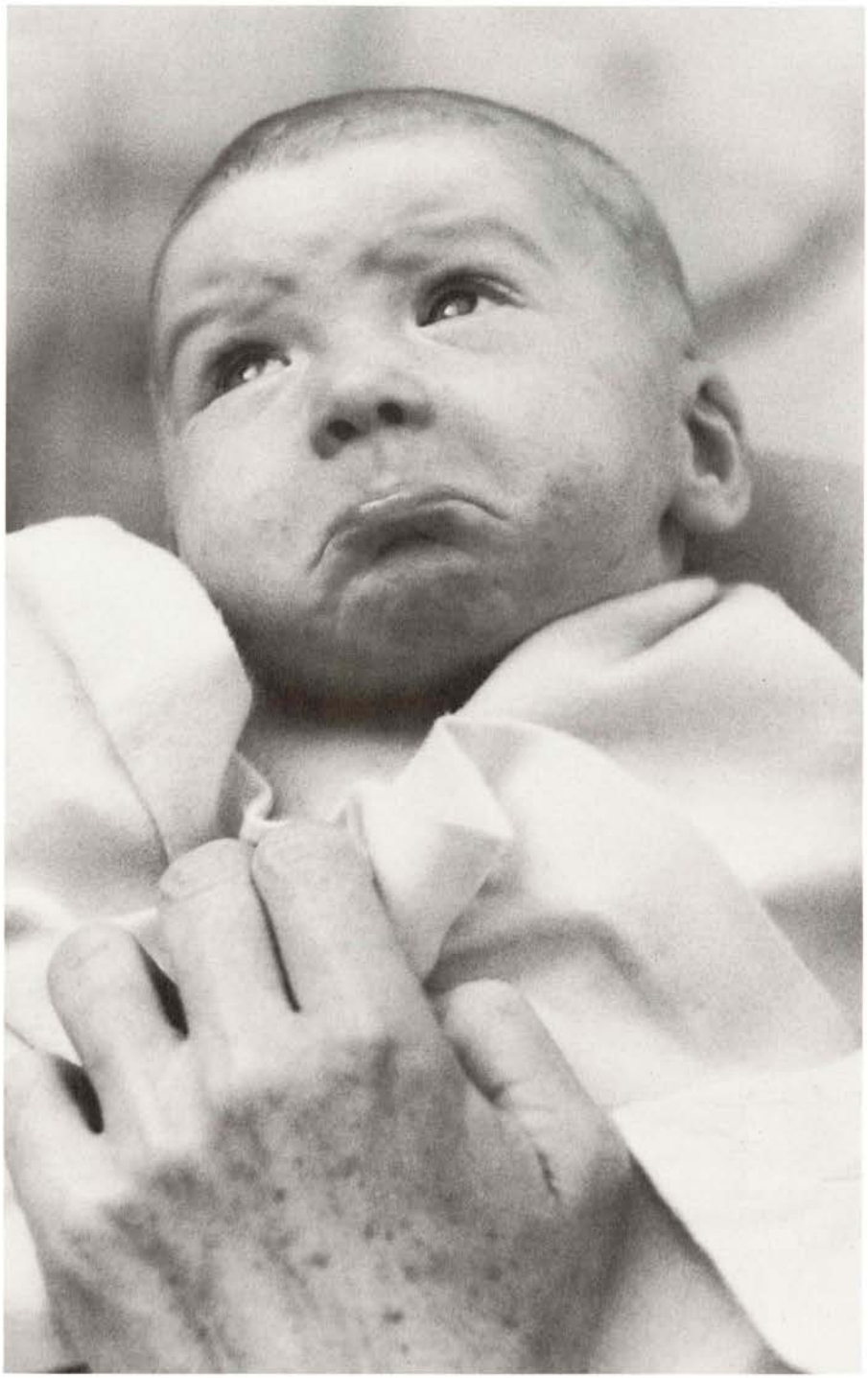
In the direct sales (individual policy) area, the Plan made significant gains as well. It exceeded ambitious goals for its Complementary Coverage II (Medicare supplement) policy, acquiring 20,000 new subscribers. The Dimension III product (individual health coverage) had a net sales increase of 30 percent in 1981.

Responding to the downward trend in local group sales, the Product Development area began work in 1981 on a new small-group product slated for introduction in the third quarter of 1982. In a departure from previous,

highly segmented small-group products, the Plan will streamline its small-group offerings by narrowing them to approximately eight programs. This is expected to result in greater market appeal; a simpler, more effective portfolio for the Plan sales force; better customer service; and more effective cost containment, since the new package will include incentives for cost containment such as broader coverage for outpatient services.

In April 1981, a corporate-wide Marketing Task Force was established for the purpose of focusing resources company-wide to support marketing efforts. Designed to cut across divisional boundaries, the Task Force was charged with developing a long-term, goal-oriented, multi-disciplinary plan to improve market performance.

In the 12-month period since its inception, the Marketing Task Force has developed comprehensive programs to present a unified plan of action through the mid-eighties. It has determined major areas for improvement, and has planned or implemented a broad range of programs that address specific problems. These include improved procedures for better customer service, training for all employees, improvement of benefit plans, better actuarial and underwriting systems, better methods for monitoring sales performance and competitor activity, and improvement of public understanding of the Plan through ongoing communications, as well as advertising and promotional activities.



COST CONTAINMENT INITIATIVES

While administrative efficiencies can significantly pare internal costs, perhaps the greatest dollar savings come from assuring that health care services themselves are rendered to consumers in the most efficient ways possible. The Plan has therefore continued to work jointly with physicians and hospitals to develop programs that restrain the rate of increase in health care costs.

Many of these initiatives have been in place for several years or more, long enough to yield results.

THE PROSPECTIVE CHARGE PAYMENT PROGRAM (PCPP)

This voluntary, sustained effort between the Florida Plan and its 232 contracting hospitals seeks to cooperatively limit the rate of increase in hospital charges by working with the hospitals before they implement increases in their charges and to limit increases for the following year. Initiated in 1977, the original PCPP proved successful in holding increases to our subscribers at one-to-two percentage points below the national average.

In June 1981, the program was revised to include stronger, more equitable controls by using more sophisticated methods of measuring the costs of the most commonly used hospital services and adjusting for changes in the numbers or kinds of patients using a given hospital.

With 198 (roughly eighty-five percent) of the Florida Plan's participating hospitals having passed

through the revised PCPP process, hospitals have agreed to reduce their prospective charges for fiscal year 1982 by $15.5 million.

HOSPITAL CHARGE AUDIT PROGRAM

This is a major cost containment effort aimed at determining if Blue Cross and Blue Shield of Florida has made proper payments for the services its subscribers have received at contracting hospitals.

Under this program, a random sample of paid inpatient hospital claims is selected for audit. If inaccuracies appear, an error rate is established for the entire sample, and money is refunded to (or by) Blue Cross and Blue Shield of Florida.

The Hospital Charge Audit Program resulted in savings to the Plan and its subscribers of over $2 million during 1981.

USUAL, CUSTOMARY, AND REASONABLE (UCR) PHYSICIANS' REIMBURSEMENT PROGRAM

Under this program, the Florida Plan performs annual audits, on a retrospective basis, to determine that proper payment has been made for inpatient services rendered to Plan subscribers.

During 1981, the UCR reimbursement program held back medical charges from levels they would otherwise have reached by approximately $11 million.

HOSPITAL UTILIZATION REVIEW (HUR) REPORTING

The Plan's Hospital Utilization Review report provides quarterly details on patient admissions to each Florida hospital by diagnosis, payment data, peer group comparisons, and average length of stay.

In addition to these hospital reporting systems, the Florida Plan has developed an account-specific analysis which examines the utilization patterns and trends for each enrolled group on an individual basis. These reports have been provided to accounts throughout the state to help them to use their health care system more efficiently.

THE OTHER CARRIER LIABILITY (OCL) PROGRAM

This program addresses cases in which two or more insurance companies are involved in a claim. Often Blue Cross and Blue Shield pays the patient's bill initially; however, in cases where another carrier more appropriately owes the claim, the carrier must refund the money to the Plan.

During 1981, the OCL Program yielded nearly $13.1 million in savings to the Plan and its customers.

STATEWIDE COOPERATIVE EFFORTS

Blue Cross and Blue Shield of Florida is pursuing cost containment goals through its support of a wide range of local and state agencies. Among other activities, the Florida Plan participates in health care services at the community level through memberships on legislative task forces, business coalitions, local health planning groups, the Hospital Cost Containment Board of Florida, and the Florida Committee on the Cost of Medical Care.

HEALTH EDUCATION INITIATIVES

Ultimately, significant savings in health care costs may occur through encouraging individuals to become more actively responsible for their own health. Blue Cross and Blue Shield of Florida, therefore, has developed a number of preventive health care initiatives for implementation in 1982, including a Health Education Program to encourage individuals to improve their health by altering lifestyles (managing stress, quitting smoking, controlling weight) and to cut down on their own health care costs by shopping prudently for health insurance and care.

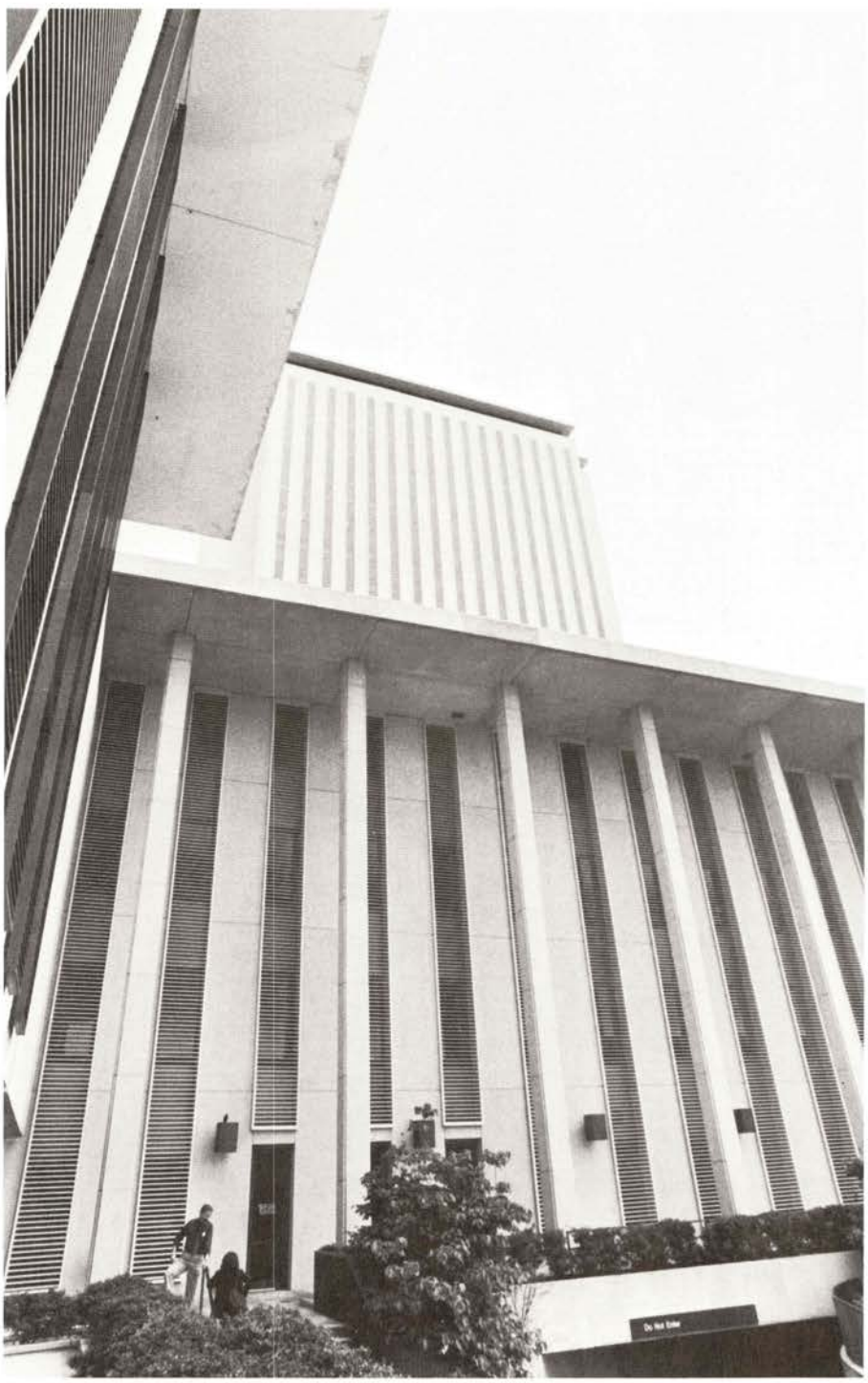
STAY WELL INCENTIVE PLAN FOR STATE OF FLORIDA GROUP

This innovative program, developed with the State of Florida, gives financial incentives to subscribers who require little or no use of their health care benefits. It was incorporated early in 1982 into the new State of Florida Employees' health care contract on a three-year test basis.

As part of its new State Employees' contract, the Florida Plan will assist the State in providing claim and utilization data for those employees volunteering for the Stay Well plan. If it shows success in reducing unnecessary use of benefits, the Stay Well program may later become an option in the Florida Plan's other private business group offerings.

The causes of rising health care costs are both complex and numerous. Many of the components of the problem—inflation, increased utilization, advances in technology, shifts in population—lie beyond the control of any one group. As a result, activities aimed at containing costs are not simple, nor do such programs yield immediate results. Still, the Florida Plan believes that costs can be held back by efficient management, innovative programs, and cooperative efforts with the groups most affected by cost problems: communities, hospitals, physicians, legislators, and the individual consumer.

A NEW CORPORATE STRUCTURE



In the mid-1940s, when the antecedent companies to Blue Cross and Blue Shield of Florida were formed, they were envisaged as non-profit health service organizations chartered to serve communities throughout the state. At that time a regulatory process was developed which has not changed significantly in many years. However, the marketplace has changed dramatically with the entry of hundreds of competitors. Today the Florida Plan, with approximately 17 percent of this market, needs to be treated on an equal basis if it is to survive and fulfill its purpose of community service.

In the 1981-82 legislative session, when the state's Insurance Code underwent Sunset Review, Blue Cross and Blue Shield of Florida requested a review of the regulatory structure to reflect the current competitive environment. On April 7, 1982, the state legislature responded by voting to enable Blue Cross and Blue Shield of Florida to become a non-profit mutual insurance company.

This change in legal status will not affect the company's goals, purposes, or objectives. The Plan has always existed for the benefit of its subscribers, a commitment it intends to maintain. In fact, as a non-profit health service organization, Blue Cross and Blue Shield of Florida has always operated like a non-profit mutual company.

However, as a mutual company, the Plan will show two noticeable changes. First, the Plan will have statutory equality with other health insurers in Florida, allow-

ing it to compete on an equal basis with commercial carriers.

Second, Blue Cross and Blue Shield of Florida's policyholders will become "members" of the corporation for as long as they hold a policy with the Plan.

Assuming approval by the Board of Directors and Active Membership, the target date for the Florida Plan to become a mutual insurer is October 1, 1982, the effective date of the Sunset Review changes to the Florida Insurance Code.

HEALTH CARE EXPERTS

During the 1981-82 Sunset Review process, members of Blue Cross and Blue Shield of Florida management repeatedly contributed data and their expertise before groups of state and federal decision-makers. Plan management made over 40 presentations before Florida House and Senate committees on subjects ranging from trends in the cost of health care to issues affecting cost containment, health planning, health maintenance organizations, mandatory co-insurance, and the extent of competition within the health care industry. In addition, Florida Plan management made presentations reflecting the company's expertise on Medicare-related issues before congressional committees and Florida's elected delegates to Washington.

Through such means, the Florida Plan continues to work with those who shape public policy, to contribute Plan experience and expertise, and to help support an effective private-sector health system that best serves the interests of our public.

NEW VENTURES

In the effort to stem rising health care costs, much can be accomplished by reforming the present system to make it as responsive and efficient as possible.

But at Blue Cross and Blue Shield of Florida, we're going beyond that: we're working to expand our business into new areas, and developing new alternatives to conventional health care delivery systems that promise to provide needed services at a competitive price.

One of these major new initiatives occurred in June 1982, when the Florida Plan joined with the Capital Health Plan to open a health maintenance organization (HMO) in Tallahassee.

The company has been exploring the feasibility of entering the HMO field since 1979. In fact, HMO development is a logical part of an overall corporate commitment to containing health care costs. The health maintenance emphasis and assumption of risk by participating doctors that characterize most HMO-type organizations make this type of health care service potentially cost efficient. The challenge is to develop a soundly managed effort that can compete successfully with other plans and programs over the long run.

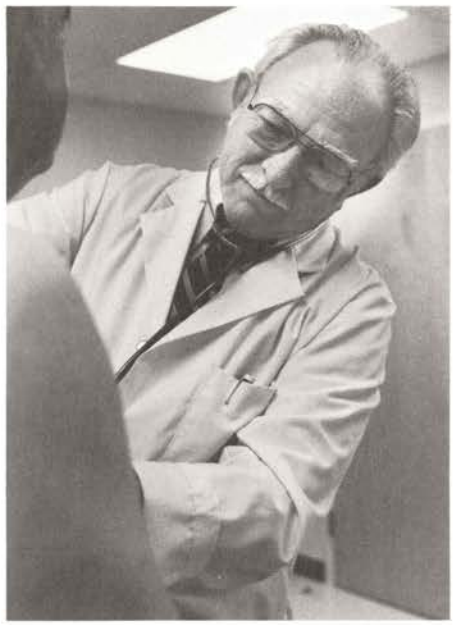
By the end of its first year, the new HMO is expected to serve about 5,000 voluntary enrollees, most of them from the state's group employee plan. By 1986, the program's fourth year, the HMO is expected to have nearly 16,000 members from a variety of

groups. At that point, the HMO should reach its financial break-even point and become self-sufficient. Until then, Florida Blue Cross and Blue Shield plans to provide up to $3 million to cover the initial start-up costs.

Another venture that is being explored has been termed the Private Sector Alternative to Medicare (PSAM). It was initiated during the fourth quarter of 1981. The PSAM proposal is based on a recent federal alternative, whereby the government would issue an annual voucher check to Medicare beneficiaries, to purchase private health insurance. Early in 1982, a concept paper developed from this alternative drew a favorable response for planning and evaluation from the Department of Health and Human Services' (HHS) Assistant Secretary. As a result, careful analysis is proceeding to see whether the Plan could offer a program that would meet beneficiary needs at a price that combines the government contribution and an affordable beneficiary premium.

Several new business ventures involve expanding Plan activities of the past. Sales of computer systems and equipment are proceeding for both providers of care and other health insurance applications. These make a significant contribution to offset Plan operating expenses.

This is a time of widespread change throughout the health care industry, and no member of the health service community is immune to these changes. Some



have proposed sweeping and radical restructuring; some have failed to act, in the hope that our present problems will be resolved by others.

At Blue Cross and Blue Shield of Florida, we believe it's time for every organization involved with health care to join with us and take a closer look at our industry's problems, and to initiate effective programs to help reduce industry costs.

Our current health care funding concerns developed over decades and represent a set of long-term problems for which there are no quick or easy solutions. However, we believe that the focus on administrative efficiency, cooperative efforts, and innovative ways of doing business described here will go far to benefit our subscribers through the eighties and beyond.

FINANCIAL REVIEW

AUDITORS' REPORT

To the Board of Directors of Blue Cross and Blue Shield of Florida, Inc.:

We have examined the balance sheet of Blue Cross and Blue Shield of Florida, Inc. as of December 31, 1981, and the related statements of operations and unallocated reserve and changes in financial position for the year then ended. Our examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. The financial statements of Blue Cross and Blue Shield of Florida, Inc. for the year ended December 31, 1980 were examined by other auditors whose report dated March 16, 1981, expressed an unqualified opinion on those statements.

In our opinion, the 1981 financial statements referred to above present fairly the financial position of Blue Cross and Blue Shield of Florida, Inc. at December 31, 1981 and the results of its operations and the changes in its financial position for the year then ended, in conformity with generally accepted accounting principles which, except for the change, with which we concur, in the method of accounting for vacation pay as described in Note 6 to the financial statements, have been applied on a basis consistent with that of the preceding year.

Coopers & Lybrand

Jacksonville, Florida
March 12, 1982

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

BALANCE SHEETS

(December 31, 1981 and 1980)

ASSETS	1981	1980
Investments:		
Bonds, at amortized cost (market $29,157,943 in 1981 and $37,733,147 in 1980)	$ 33,666,570	$ 42,697,196
Stocks, at market (cost $8,512,351 in 1981 and $8,320,292 in 1980)	9,389,125	10,203,262
Short-term investments	53,289,067	40,986,361
Cash held for investment	5,419	47,924
Florida Combined Insurance Agency, Inc.	626,501	546,737
Total investments	96,976,682	94,481,480
Cash	33,148	35,233
Accrued interest receivable	2,732,843	2,191,581
Reimbursement contracts receivable	39,152,000	32,665,000
Receivables	37,034,171	33,560,363
Property and equipment, at cost less accumulated depreciation	22,808,517	20,474,765
Prepaid expenses and other assets	888,121	811,330
Total assets	$199,625,482	$184,219,752
LIABILITIES		
Reserve for subscriber benefits:		
Claims outstanding	$ 42,942,000	$ 44,231,000
Reimbursement contracts	39,152,000	32,665,000
Total reserve for subscriber benefits	82,094,000	76,896,000
Bank overdrafts	11,573,785	9,695,345
Provision for experience rating refunds	1,770,562	1,774,352
Deferred income—subscribers' fees paid in advance and unallocated receipts	17,237,122	15,475,993
Deposits and advances payable	16,865,839	12,057,675
Accounts payable and accrued expenses	9,803,241	8,280,705
Total liabilities	139,344,549	124,180,070
Commitments and litigation (notes 7, 9 and 10)		
UNALLOCATED RESERVE		
Unallocated reserve	60,280,933	60,039,682
Total liabilities and unallocated reserve	$199,625,482	$184,219,752

See accompanying notes to financial statements.

STATEMENTS OF OPERATIONS AND UNALLOCATED RESERVE

(for the years ended December 31, 1981 and 1980)

	1981	1980
Subscribers' fees earned	$484,656,559	$427,726,823
Claims expense	454,725,413	407,707,908
Operating expenses	40,320,812	32,291,357
Total claims and operating expense	495,046,225	439,999,265
Operating loss	(10,389,666)	(12,272,442)
Other income (losses):		
Investment and other income	14,419,522	12,794,406
Realized investment losses	(1,468,408)	(262,829)
Total other income	12,951,114	12,531,577
Income before cumulative effect of change in accounting principle	2,561,448	259,135
Cumulative effect of change in method of accounting for vacation pay	1,314,000	-
Net income	1,247,448	259,135
Unallocated reserve, beginning of year	60,039,682	58,244,681
Current year increase (decrease) in market value of stocks	(1,006,197)	1,535,866
Unallocated reserve, end of year	$ 60,280,933	$ 60,039,682

See accompanying notes to financial statements.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

STATEMENTS OF CHANGES IN FINANCIAL POSITION

(for the years ended December 31, 1981 and 1980)

	1981	1980
Funds provided from operations:		
Net income	$ 1,247,448	$ 259,135
Charges (credits) to operations not requiring funds:		
Decrease (increase) in certain assets:		
Accrued interest receivable	(541,262)	(1,261,915)
Reimbursement contract receivables	(6,487,000)	(9,014,000)
Receivables	(3,473,808)	(9,646,042)
Equity in net earnings of Florida Combined Insurance Agency, Inc.	(79,764)	(204,175)
Depreciation	1,667,330	1,474,410
Amortization of bond discounts, net	(496,609)	(955,651)
Increase (decrease) in certain liabilities:		
Reserve for subscriber benefits	5,198,000	20,841,000
Bank overdrafts	1,878,440	9,695,345
Provision for experience rating refunds	(3,790)	(6,082,795)
Refund to subscribers	-	(3,150,506)
Deferred income—subscribers' fees paid in advance and unallocated receipts	1,761,129	2,531,034
Accounts payable and accrued expenses	1,522,536	2,983,603
Funds provided from operations	2,192,650	7,469,443
Other funds provided (used):		
Investments:		
Sales:		
Bonds	35,108,836	36,217,324
Stocks	93,930,888	5,644,013
Purchases:		
Bonds	(25,581,601)	(39,649,511)
Stocks	(94,122,947)	(5,342,394)
Short-term investments, net	(12,302,706)	(7,448,325)
Purchase of property and equipment	(4,001,083)	(1,139,126)
Deposits and advances payable	4,808,164	1,486,957
Other	(76,791)	(113,085)
Increase (decrease) in cash and cash held for investment	$ (44,590)	$ 2,874,704

See accompanying notes to financial statements.

NOTES TO FINANCIAL STATEMENTS

1. **Summary of Significant Accounting Policies:** Blue Cross and Blue Shield of Florida, Inc. (the "Plan") was incorporated on July 1, 1980 to consolidate Blue Cross of Florida, Inc. and Blue Shield of Florida, Inc.

   The Plan is subject to regulation by the Insurance Department of the State of Florida. The Plan provides basic medical, hospitalization and other health benefits along with major medical, comprehensive and complementary coverages to its subscribers. The Plan also processes claims for other Blue Cross and Blue Shield plans' subscribers and for programs such as Medicare and Federal Employees Health Benefits Program ("FEP").

   The Plan is a member of the Blue Cross Association and the Blue Shield Association. These associations establish national policies and set standards for the programs.

   The statutory financial statements of the Plan, which are filed with the State Insurance Department, have been adjusted to conform with generally accepted accounting principles (GAAP). The major accounting principles and practices followed by the Plan are presented below to assist the reader in evaluating the accompanying financial statements and notes.

   a. Investments:

   Bonds are carried at amortized cost adjusted where appropriate for amortization of premium and discount. No provision has been made for the excess of cost over market value of bonds since the Plan generally intends to hold such investments to maturity and does not expect to realize any significant losses.

   Common and preferred stocks are carried at market value. Net unrealized gains at December 31, 1981 consist of gross unrealized

gains of $883,274 and gross unrealized losses of $6,500.

Short term investments consist of U.S. treasury bills and notes, repurchase agreements, commercial paper, and other federally insured investments. These investments are stated at cost and mature within two years.

Realized investment gains and losses are calculated on the basis of specific identification at the time investment securities are sold.

Florida Combined Insurance Agency, Inc. (the "Agency") is a wholly-owned subsidiary of the Plan. The Agency acts as an agent or broker when group life, accident or disability insurance is sold as a package with the Plan's health coverages. Investment in the Agency is accounted for using the equity method. Equity in the earnings of the Agency of $79,764 and $204,175, has been included in investment income for the years 1981 and 1980 respectively.

b. **Subscribers' Fees Earned:**
Subscribers' premiums are billed in advance of their respective coverage periods. Receivables and income are recorded for the unpaid, earned portion of the billings. The unearned portion of premiums paid by subscribers is recorded as deferred income and transferred to subscribers' fees as earned.

c. **Property and Equipment:**
Property and equipment are recorded at cost, which includes expenditures for significant improvements. Maintenance, repairs and minor improvements are expensed as incurred. When assets are retired or otherwise disposed of, cost and accumulated depreciation are removed from the accounts and any resulting gain or loss is reflected as other income. Depreciation is computed on the straight-line method over their estimated useful lives.

d. **Reserve for Subscriber Benefits:**
The Plan provides for incurred and unreported subscriber claims based on historical paid claims data and experience using actuarially accepted statistical methods. Processing expenses related to such claims are accounted for as paid. The methods used in determining the reserves are periodically reviewed and any adjustments resulting from these revisions are reflected in operations currently.

e. **Provision for Experience Rating Refunds:**
Under certain group contracts, the Plan's income (retention fee) is limited to a predetermined percentage of either total subscriber fees or incurred claims. Any excess of subscriber fees over incurred claims and retention fees accrues to the policyholder. Depending on the terms of the contract, such excess may be refunded in cash, utilized to increase benefits or reduce subscribers' fees in subsequent periods.

f. **Expense Reimbursements:**
Operating expenses are allocated by various lines of business in order to determine the expense reimbursement due from Medicare, where the Plan acts as a fiscal intermediary, and also from other Federal health programs and other Blue Cross and Blue Shield plans for which the Plan processes claims. The Plan is reimbursed for either actual costs incurred or amounts based on predetermined budgets. Such reimbursements, pursuant to industry practice, are offset against operating expenses in the accompanying financial statements. Reimbursements and claims payments are subject to audit by the respective agencies and any resulting adjustments are reflected in operations currently.

g. **Pension Plan:**
Pension expense includes amortization of prior service costs. The Plan's policy is to fund pension costs accrued which are composed of normal costs and amortization of prior service costs.

h. **Income Taxes:**

The Plan is a non-profit corporation and is exempt from both Federal and state income taxes.

i. **Reclassification:**
Certain amounts in 1980 have been reclassified to conform with presentations adopted in 1981.

2. **Property and Equipment:**
The Plan's property and equipment at December 31, 1981 and 1980 is summarized below:

	1981	1980
Land	$ 2,121,594	$ 2,121,594
Buildings	24,784,018	23,394,570
Equipment	8,262,546	6,080,473
Total property & equipment	35,168,158	31,596,637
Less accumulated depreciation	12,359,641	11,121,872
Net property & equipment	$22,808,517	$20,474,765

3. **Reserve for Subscriber Benefits:**
The reserve for subscriber benefits provides for incurred, incomplete and unreported claims and is calculated using a projected pure premium developed by actuarially accepted statistical methods. The estimated reserves relating to National, FEP and Cost Plus (reimbursement contracts) are also established as a receivable and thus have no effect on net income. The Plan receives administrative fees or expense reimbursement for these lines of business and is reimbursed for incurred claims.

The Plan participation in a reinsurance agreement with Health Services, Inc., wholly-owned by BCA, was cancelled 2/1/81.

4. **Agency Contracts:**
The Plan serves as intermediary for the Medicare program. Claims relating to this program are not reflected in the accompanying financial statements. Unaudited results of this program indicate the Plan processed approximately 11,800,000 and 10,970,000 claims totalling approximately $2,422,233,000 and

$1,988,300,000 during 1981 and 1980, respectively.

The Plan acts as Administrator for the State of Florida—Employee Group Health Self-Insurance Plan. Claims relating to the agreement are not reflected in the accompanying financial statements. Approximately 288,000 and 217,000 claims totalling $57,821,000 and $43,411,000 were processed by the Plan for 1981 and 1980, respectively.

Reimbursements for the administrative cost of services performed for governmental agencies, the State of Florida self-insurance plan and other plans totalled approximately $41,700,000 and $39,200,000 in 1981 and 1980, respectively, and have been offset against operating expenses.

5. **Employee Pension Plan:**
The Plan participated in a noncontributory pension plan for the benefit of all its employees. The pension plan is funded through the Blue Cross and Blue Shield National Retirement Trust, a collective investment trust which services the retirement programs of its participating employers. Pension expense for the Plan amounted to $1,887,374 and $2,099,197 in 1981 and 1980, respectively. As of the most recent valuation date, the unfunded actuarial liability was approximately $6,389,232. A comparison of accumulated pension plan benefits and pension plan assets for the Plan is presented below:

Actuarial present value of accumulated plan benefits:	January 1, 1981
Vested	$ 9,894,907
Non-vested	2,312,560
	$12,207,467
Net assets available for benefits	$19,508,807

The weighted average assumed rate of return used in determining the actuarial present value of accumulated pension plan benefits was 7% for 1981.

6. **Vacation Policy:**
At December 31, 1981 the Plan conformed to the Financial Accounting Standards Board's Statement No. 43, "Accounting For Compensated Absences." This required the Plan to change from its practice of recognizing employee vacation costs when paid to accruing for these costs when earned by employees. This change provides for the accrual of vacation pay on substantially all of the Plan's eligible employees. The effect of the accounting change in the accompanying statement of operations was to reduce net income by $1,314,000.

7. **Rentals Under Operating Leases:**
The Plan leases office space, data processing equipment and automobiles. The Plan also leases office space to tenants. The leases in effect or committed at December 31, 1981 expire on various dates through 1987. The following is a schedule by years of future approximate minimum rental payments for the Plan under operating leases that have initial or remaining noncancellable lease terms in excess of one year as of December 31, 1981:

Year ending December 31	Basic rental commitments	Basic rental income
1982	$2,604,000	$511,000
1983	2,149,000	170,000
1984	740,000	-
1985	370,000	-
1986	296,000	-
1987	77,000	-
	$6,236,000	$681,000

Rental expense for 1981 and 1980 was $3,435,000 and $3,220,000, respectively.

8. **Supplementary Data:**
Following is a reconciliation of net income and unallocated reserve on the basis of statutory accounting principles to the amounts reported in the accompanying GAAP financial statements.

	1981	1980
Net income—statutory basis	$ 1,167,684	$ 54,960
GAAP adjustments—equity in undistributed earnings of FCIA	79,764	204,175
Net income—GAAP basis	$ 1,247,448	$ 259,135
Unallocated reserve—statutory basis	$64,128,241	$66,311,246
Non-admitted assets, principally equipment and miscellaneous accounts receivable	3,018,728	2,376,417
Excess of appraised value of real estate over book value	(6,866,036)	(8,647,981)
Unallocated reserve—GAAP basis	$60,280,933	$60,039,682

9. **Litigation:**
In 1979, the Plan realized an investment loss of approximately $4,144,000 resulting from transactions with two securities brokers who became involved in bankruptcy proceedings. The loss included the write-off of investment balances with the brokers plus an estimate of additional amounts which may be contested during the brokers' bankruptcy proceedings.

In connection with the transactions with one of the brokers, the Plan, in February 1980, was named as defendant in a lawsuit seeking damages of $2,000,000 plus interest and costs. Discovery has begun and an answer to the complaint denying the allegations has been filed. The case is in the early stage of the proceedings; however, the Plan's general counsel is of the opinion that the Plan has adequate defenses which it plans to vigorously pursue and that the resolution of this matter will have no material adverse effect on the Plan's financial condition.

10. **Commitments:**
On December 3, 1981, the Plan entered into an affiliation agreement with Capital Group Health Services of Florida, Inc. ("CHP"), a health maintenance organization. The agreement gives the Plan majority control of the corporate membership of CHP. As part of the agreement, the Plan has committed to loan CHP $3,000,000 initially, with a commitment for additional financing if necessary. The agreement also provides that the Plan may provide certain administrative services and products.

BOARD ACTIVITIES

During 1981, the Board of Directors of Blue Cross and Blue Shield of Florida was active in providing guidance and support to the corporation. The Board was particularly involved in the areas of new programs and policy development, with emphasis on rating and regulation, finances, cost containment, and HMO development. The 1981 activities of the Plan's ten Board Committees included the following:

- Executive Committee (the late G. Emerson Tully, chairman*): During 1981, the Executive Committee continued to exercise its responsibility to oversee the affairs and business of Blue Cross and Blue Shield of Florida. It has provided in-depth reviews of rates and financial implications of both regulatory decisions and organizational structures.
- Audit Committee (Robert P. Evans, chairman): The Committee selected a new accounting firm, Coopers & Lybrand, and supervised their work in connection with the annual audit of financial statements, as well as the Plan's many audit programs.
- Health Maintenance Organization (HMO) Committee (William V. Roy, chairman): The HMO Committee had a very active year in 1981, in two major areas. On the basis of an extensive feasibility study performed by the Florida Plan's HMO Development area, the Committee recommended to the full Board that the Plan proceed with HMO planning and development. In addition, the Committee made a decision to develop an affiliation agreement with Capital Health Plan that resulted in the opening of an HMO in Tallahassee, affiliated with the Florida Plan.
- Cost Containment Committee (G. Hunter Gibbons, chairman): During 1981, the Committee reviewed proposals and alternatives for such major corporate initiatives as the revised Prospective Charge Payment Program; HMO development, particularly with reference to the Capital Health Plan; and changes in determining the reimbursement levels for UCR (usual, customary, and reasonable reimbursements for doctors' charges). In addition, the Committee reviewed individual requests for significant rate adjustments by contracting hospitals.
- Finance, Capital Investment and Facility Planning Committee (Lewis A. Doman, Jr., chairman): Activities for the Committee during 1981 included approval of consolidated investment objectives and policies for the corporation, investment transactions, building improvements, and review of the financial proposal recommended by the ad hoc HMO Committee.
- Institutional Affairs Committee (Middleton T. Mustian, chair-

man): During 1981, the Committee evaluated and took action on 33 health care facilities. In addition, it advised the full Board on such major new programs as the revised Prospective Charge Payment Program and the Capital Health Plan HMO. The Committee reviewed and recommended to the Board policies for full contracting status for specialty hospitals.

- Marketing and Public Affairs Committee (Frederick B. Youngblood, chairman): The Committee continued in 1981 to review corporate programs and management studies of marketing and communications activities. The year's activities included review of the Blue Cross and Blue Shield results by market segment, rating requirements, and support for the Plan's legislative efforts during the Sunset Review of the Florida Insurance Code. In addition, a special review was conducted on the statewide consumer opinion survey completed by the Plan in October 1981.
- Medical Affairs Committee (Joseph G. Matthews, chairman): Among the Committee's 1981 activities were several joint meetings with the Board's Cost Containment Committee, to discuss UCR (usual, customary, and reasonable) methods of reimbursing physicians, as well as to review the company's proposed HMO planning and development activities. In addition, the Committee developed information about membership criteria and functions of the Plan's Claims Committee.
- Nominating Committee (Helen B. Adams, chairman): The Committee's activities during 1981 included a continuing review of guidelines and membership issues, as well as making recommendations to the full Board that resulted in the election of 12 new Active Members.
- Personnel and Compensation Committee (Clarence G. King, Jr., chairman): During 1981, the Committee continued to review and provide guidance to annual changes in corporate compensation and benefit programs; and to fulfill its oversight responsibility for all major Human Resource programs.

As this broad range of committee activity suggests, the Board of Directors of the Florida Plan maintained, in 1981, their strong support for the corporate effort to design innovative solutions to health care cost and delivery problems. Based on their guidance, leadership, and experience, the Florida Plan was able to develop such major corporate initiatives as its first venture into health maintenance organizations and many of its effective cost containment programs.

*Joseph G. Matthews, Vice Chairman of the Board, has presided at Executive Committee meetings since the death of Mr. Tully in April 1982.

BOARD OF DIRECTORS AND ACTIVE MEMBERSHIP, AS OF JUNE 30, 1982

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G. Emerson Tully †**
Educator, Retired
Tallahassee

VICE CHAIRMAN OF THE BOARD

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Orthopedic Surgeon
Orlando

FLORIDA PLAN PRESIDENT

William E. Flaherty**
Blue Cross and Blue Shield of Florida, Inc.
Jacksonville

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President, Fanad Managment, Inc.
Orange Park

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Thoracic Surgery
Gainesville

Harry W. Bower, CPA*
Partner, Retired
Ernst & Ernst
Orlando

E. Wayne Christopher*
Executive Director
Parkway General Hospital
North Miami Beach

Richard C. Clay, M.D.**
General Surgery
Miami

Mary H. Cross*
Community Affairs Leader
St. Petersburg

Tracy Danese
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Vice President, Florida Power and Light
Juno Beach

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President, The Citizens and Peoples National Bank
Pensacola

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Evans, Parrish and Fisk, CPAs
Lakeland

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Urologist
Gainesville

H. Jackson Floyd
Executive Director
Memorial Hospital of Sarasota
Sarasota

Michael J. Foley, M.D.*
General Surgery
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G. Hunter Gibbons*
Attorney
Dickinson, O'Riorden, Gibbons, Quale, Shields and Carlton, P.A.
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Cardiologist
Orlando

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Nephrologist
Jacksonville

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President/Owner
Var Heyl Lincoln-Mercury, Inc.
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Pensacola

Charles J. Kahn, M.D.
Internal Medicine
Pensacola

John T. Kilpatrick, M.D.
General Surgeon
Coral Gables

Clarence G. King, Jr.**
Attorney, Partner, Retired
Rogers, Towers, Bailey, Jones & Gay
Jacksonville

Bently B. Lang*
Administrator
Manatee Memorial Hospital
Bradenton

Robert F. Lanzillotti
Professor of Economics and Dean of the Graduate School of Business and School of Accounting
University of Florida
Gainesville

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Barnett Banks of Florida, Inc.
Jacksonville

P. Scott Linder
Chairman
Linder Industrial Machinery Co.
Lakeland

Sister Elizabeth Ann Lingg, D.C.
President
St. Vincent's Medical Center
Jacksonville

Jan B. Luytjes, Ph.D.*
Professor, School of Business and Organizational Sciences
Florida International University
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Raul P. Masvidal
Chairman of the Board and President
Biscayne Bank
Miami

Wallace E. Mathes, Jr.*
Senior Resident, Vice President and Manager
Merrill Lynch, Pierce, Fenner and Smith, Inc.
Jacksonville

Middleton T. Mustian**
President/Chief Executive Officer
Tallahassee Memorial Regional Medical Center
Tallahassee

Ernest C. Nott, Jr.
Chief Executive Officer
Baptist Hospital of Miami, Inc.
Miami

Edward C. Peddie
President and Chief Executive Officer
Alachua General Hospital
Gainesville

Eugene G. Peek, Jr., M.D.*
Family Practice
Ocala

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Enterprise Building Corporation
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Community Affairs Leader
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John A. Turner, CPA
Secretary Treasurer
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Lakeland

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Melbourne

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Fort Lauderdale

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William E. Flaherty
President/Chief Executive Officer

J. W. Bolin
Vice President
Systems/Information Operations

Michael Cascone, Jr.
Senior Vice President
Marketing

Robert L. Cunningham
Vice President
Corporate Research and Industrial Relations

Robert H. Endriss
Vice President
Corporate Planning

James P. Galasso
Vice President and Actuary

Francis J. Greaney
Senior Vice President
Health Industry Services

J. D. Lewis, Jr.
Senior Vice President
Operations

James W. Martin
Senior Vice President
Finance/Corporate Treasurer

John S. Slye
Vice President
Public Affairs/Corporate Secretary

†Deceased
*Member of the Board of Directors
**Member of the Executive Committee of the Board of Directors

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